FLAT BUSH MEDICAL CENTRE ENROLMENT FORM

ALLIANCE HEALTH+
Inspiring Health Transformation

201 Murphys Road, Flat Bush, Auckland 2016
Phone: 09 930 8314 Fax: 09 930 8318

EDI: flatbush
GP Provider: Dr Vandana Rasela
NZMC no: 35912

				*NHI	
Title		*First Name(s)		*Family Name	
Other Names Known By (eg. maiden name, etc). Please tick the name you prefer to be known as				*Date of Birth	____/____/____ Day Month Year
*Gender	☐ Male ☐ Female ☐ Gender Diverse (pl state)			*Place & Country of Birth	
*Physical Address	Street number	Name of Street		Occupation	
	Suburb			*High User Health Card Card Number & Expiry Date:	YES / NO
	City/Town	Postcode			
Postal Address				Community Services Card Card Number & Expiry Date:	YES / NO
Contact Details	Day Phone	Night Phone	Mobile No (tick box to accept txts) ☐	Email (tick box to accept emails) ☐	
Emergency contact	Name of person to contact		Relationship	Phone Number	

*Which ethnic group do you belong to? Tick the space or spaces which apply to you	Smoking Status	*Eligibility *(see over page)* I confirm that, if requested, I can provide proof of my eligibility. I agree to inform the practice of any changes in my eligibility.	
☐ New Zealand European	☐ Current	*Eligible under criteria (enter applicable letter from list over page)	*
☐ Māori Iwi:		I have read and agree to the Enrolment Process, the Health Information Privacy Poster/Statement, and Patient Experience Survey. (Tick)	*
☐ Samoan	☐ Ex-Smoker		
☐ Cook Islands Maori	☐ Never Smoked	NOT Eligible (Tick if not eligible under any criteria over page)	
☐ Tongan			
☐ Niuean	Transfer of Records ☐Yes ☐No ☐Not Applicable		
☐ Chinese	In order to get the best care possible, I agree to the transfer of my records from my previous Doctor. I understand I will be removed from their practice register.		
☐ Indian	Doctor's Name:		
☐ Other such as DUTCH, JAPANESE, TOKELAUAN, FIJIAN Please state:	Address / Location: Phone/Fax:		

*SIGNATURE	*DATE
	/ / Day Month Year

OR Signed by AUTHORITY[11] An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Full Name of Authority	Contact Phone Number	Relationship
Address	Signature of Authority	/ / Day Month Year
Detail the basis of authority (e.g. parent of a child under 16):		